CITY OF SCOTTSDALE 2004/2005 BENEFITS ENROLLMENT FORM

☐ New Enrollment ☐ Change in Enrollment ☐ Dependent Change ☐ Termination of Coverage	Qualifying Event: _____ Qualifying Event Date & Effective Date: _____

FOR HUMAN RESOURCES USE ONLY	Received on:
____ Original to Medical File _____ Copy to Payroll on: _____ ____ Copies to Billing File _____ COBRA Notice Sent _____ DP Change Copy to MSIM	

Enrollee Last Name	First Name, MI	Employee Number or Social Security Number
Date of Birth	Home Phone	Work Phone

MEDICAL

☐ **AETNA OPEN ACCESS EPO** (408)
☐ **MAYO HEALTH TRADITION PPO** (410)
☐ **AETNA OPEN CHOICE PPO** (418)
☐ WAIVE MEDICAL
If you are a full time employee, you must provide proof of other coverage

LEVEL of COVERAGE
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

DENTAL

☐ **ASSURANT DENTAL (HMO)** (425)
Enrollee's Dental Facility ID# _____
☐ **CITY OF SCOTTSDALE SCOTTSMILES PPO DENTAL** (420)
☐ NO DENTAL

LEVEL OF COVERAGE
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

SUPPLEMENTAL LIFE INSURANCE
You may apply for new coverage or changes at any time. Forms are located at www.ScottsdaleAZ.gov/jobs/benefacts

CANCER & CRITICAL CARE COVERAGE
For enrollment or changes call Colonial Life & Accident 1-800-845-7330

AETNA LONG TERM CARE
For enrollment or changes call Aetna Long Term Care 1-800-537-8521 or www.aetna.com/group/scottsdale

ALTERNATIVE MEDICINE

☐ ALTERNATIVE HEALTHCARE OPTIONS (431)
☐ NO ALTERNATIVE MEDICINE

LEVEL OF COVERAGE
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

ENHANCED VISION

☐ EYEMED VISION CARE (432)
☐ NO ENHANCED VISION

LEVEL OF COVERAGE
Is this a coverage level change? ☐ Yes ☐ No
☐ Enrollee
AND
☐ Spouse
☐ Domestic Partner*
☐ Child(ren)
☐ Domestic Partner's Child(ren)

SHORT TERM DISABILITY

WEEKLY BENEFIT (430)
☐ NO SHORT TERM DISABILITY
☐ $100/week (01)
☐ $200/week (02)
☐ $250/week (03)
☐ $300/week (04)
☐ $350/week (05)
☐ $400/week (06)
☐ $500/week (07)
(Short Term Disability Coverage cannot exceed 70% of your weekly salary)

HEALTH CARE SPENDING ACCOUNT (455)

☐ NO
☐ YES Designate Annual Amount: $_____ (Maximum $3,000 per year)

DEPENDENT CARE ASSISTANCE PLAN (460)

☐ NO
☐ YES Designate Annual Amount: $_____ (Maximum $5,000 per year)

TWO SIDED FORM – BE SURE TO COMPLETE REVERSE SIDE

CITY OF SCOTTSDALE 2004/2005 BENEFITS ENROLLMENT FORM

DEPENDENTS (LIST ALL DEPENDENTS TO BE ENROLLED)

Spouse Name (Last, First MI) ☐ Add ☐ Delete	Date of Birth		Gender
Spouse is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision			
Domestic Partner's Name* (Last, First MI) ☐ Add ☐ Delete	Date of Birth		Gender
Domestic Partner is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision			
Dependent 1 Name (Last, First MI) ☐ Add ☐ Delete	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender
Dependent 1 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision			
Dependent 2 Name (Last, First MI) ☐ Add ☐ Delete	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender
Dependent 2 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision			
Dependent 3 Name (Last, First MI) ☐ Add ☐ Delete	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender
Dependent 3 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision			
Dependent 4 Name (Last, First MI) ☐ Add ☐ Delete	Date of Birth	Relationship ☐ Child ☐ Legal Dependent ☐ Dom Partner Child	Gender
Dependent 4 is covered on the following plan(s): ☐ Medical ☐ Dental, if Assurant give dependent's dental facility #: ☐ Alternative Medicine ☐ Enhanced Vision			

Additional dependents may be listed on a separate page.

AUTHORIZATION: By execution of this enrollment form, I understand that I may not change the election except in the event of a life change or during open enrollment. I authorize the City of Scottsdale to make the necessary before-tax and after-tax payroll deduction(s). I also understand that I am responsible for reimbursement to the City for any benefit amount paid to me/for me in advance of my payroll deduction. By my signature, I certify that the information on this form is true and correct, and that the listed dependents are my legal dependents.

Signature _____ Date _____

HR Signature_____ Date _____

***DOMESTIC PARTNERSHIP COVERAGE**

In addition to all other rules and conditions of city insurance coverage, the following apply to domestic partners coverage: In order for an enrollee to enroll a domestic partner for insurance coverage, both the enrollee and the domestic partner must complete the Domestic Partnership Affidavit. City of Scottsdale Human Resources must approve the affidavit prior to the commencement of coverage. Those with affidavits already on file do not have to resubmit. The portion of the insurance premium paid by the enrollee for domestic partner and children of the domestic partner is paid on an after-tax basis. The portion of the premium paid by the City for domestic partner and children of the domestic partner is reported to the Internal Revenue Service as taxable income to the enrollee. City enrollees who have domestic partnership insurance coverage are required to complete a Termination of Domestic Partnership form within 30 days of the termination of the domestic partnership. Children of a domestic partner may enroll for coverage only if the domestic partner is enrolled for coverage.

QUALIFIED LIFE STATUS CHANGES

You may not make changes to your benefit plans until the next open enrollment unless you experience a qualified life status change such as the birth of a child, marriage or divorce. If you experience a qualified life status change, you may add or cancel dependents but you may not change plans. You must notify HR within 30 days of a qualifying life status change. It is your responsibility to notify HR when a dependent (spouse/domestic partner or child) is no longer eligible for coverage. Failure to cancel an ineligible dependent from your coverage within 30 days will make you responsible for any claims incurred by an ineligible dependent and may result in disciplinary action up to and including termination.